

**DEPARTMENT  
POLICY****Medicaid Only**

Transitional Medical Assistance (TMA) is an automatic coverage group. Transitional Medical Assistance (TMA) eligibility is only considered after LIF.

Individuals may receive TMA for up to 12 months when ineligibility for LIF relates to income from employment of a caretaker relative.

TMA starts the month in which LIF ineligibility began regardless of when the LIF eligibility actually ended.

A new or updated application for healthcare coverage is not required to transfer to Transitional Medical Assistance (TMA).

**INITIAL TMA  
ELIGIBILITY**

LIF must be transferred to TMA when **all** of the requirements below are met.

1. At least one LIF qualified group member was eligible for and received LIF for three of the six calendar months immediately preceding the month of LIF ineligibility.
2. LIF ineligibility resulted from excess earned income **only**.
3. Earnings of the caretaker relative, caretaker relative's spouse or a dependent child's parent in the LIF ineligibility determination are greater than zero.

**TMA Group**

The TMA group is those individuals who were in the LIF group at the time of transfer to TMA.

**Note:** Newborns eligible under BEM 145 may be added to the TMA case, but are not TMA group members.

**CONTINUED  
ELIGIBILITY**

TMA eligibility continues until the end of the 12-month TMA period unless:

- A change is reported, such as decreased earned income, and the family is eligible for LIF; or

**Note:** The family might qualify for TMA or Special N/Support if they again become ineligible for LIF.

- For individual members, information is reported indicating that a member does not meet the MA requirements in:
  - BEM 220, Residence.
  - BEM 257, Third Party Resource Liability.
  - BEM 265, Institutional Status.

If a member loses TMA eligibility during the 12-month period based on BEM 220, 257 or 265, but the reason for ineligibility ceases, TMA eligibility exists again.

Eligibility restarts the month ineligibility ceased and continues for the remainder of the 12-month period. The beneficiary is responsible for reporting the change that re-establishes eligibility.

**Note:** An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories. See BAM 115 and 220.

## LEGAL BASE

### MA

Social Security Act, Section 1925, 1931

## JOINT POLICY DEVELOPMENT

*Medicaid, Transitional Medical Assistance (TMA), and Maternity Outpatient Medical Services (MOMS) policy has been developed jointly by the Department of Community Health (DCH) and the Department of Human Services (DHS).*